CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Community Alternatives

(Amendment)

907 KAR 1:595. Model Waiver II service coverage and reimbursement policies and requirements.

RELATES TO: KRS 314.011, 42 C.F.R. 440.70, 440.185, 42 U.S.C. 1396, 42 U.S.C. 1396n(c)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1315

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented, to qualify for federal Medicaid funds. This administrative regulation establishes the service coverage and reimbursement policies and requirements relating to Model Waiver II services provided to a Medicaid-eligible recipient. These services are provided pursuant to a 1915(c) home and community based waiver granted by the U. S. Department for Health and Human Services in accordance with 42 U.S.C. 1396n(c).

Section 1. Definitions. (1) "1915(c) home and community based waiver program" means a Kentucky Medicaid program established pursuant to and in accordance with

42 U.S.C. 1396n(c).

(2) "Department" means the Department for Medicaid Services or its designee.

(3) "Federal financial participation" is defined in 42 C.F.R. 400.203.

(4) "Home health agency" means an agency that is:

(a) Licensed in accordance with 902 KAR 20:081;

(b) Medicare certified; and

(c) Medicaid certified.

(5) "Licensed practical nurse" is defined by KRS 314.011(9).

(6) "Model Waiver II services" means 1915(c) home and community based waiver program in-home ventilator services provided to a Medicaid-eligible recipient who:

(a) Is dependent on a ventilator; and

(b) Would otherwise require a nursing facility level of care in a hospital based nursing facility which will accept a recipient who is dependent on a ventilator.

(7) "MWMA portal" means the Kentucky Medicaid Waiver Management Application internet portal located at http://chfs.ky.gov/dms/mwma.htm.

(8) "Participant" means a recipient who qualifies for and is receiving Model Waiver II services in accordance with Section 2 of this administrative regulation.

(9) "Person-centered service plan" means a written individualized plan of services.

(10) "Private duty nursing agency" means a facility licensed to provide private duty nursing services:

(a) By the Cabinet for Health and Family Services, Office of Inspector General; and

(b) Pursuant to 902 KAR 20:370.

(11)[~~(8)~~] "Recipient" is defined by KRS 205.8451(9).

(12)[~~(9)~~] "Registered nurse" is defined by KRS 314.011(5).

(13)[~~(10)~~] "Registered respiratory therapist" is defined by KRS 314A.010(3)(a).

(14)[~~(11)~~] "Ventilator" means a respiration stimulating mechanism.

(15)[~~(12)~~] "Ventilator dependent" means the condition or state of an individual who:

(a) Requires the aid of a ventilator for respiratory function; and

(b) Meets the high intensity nursing facility patient status criteria established in 907 KAR 1:022.

Section 2. Participant [~~Model Waiver II Recipient~~] Eligibility and Related Policies.

(1)(a) To be eligible to receive Model Waiver II services, an individual shall:

1. [~~(a)~~] Be eligible for Medicaid pursuant to 907 KAR 20:010;

2. [~~(b)~~] Require ventilator support for at least twelve (12) hours per day; and

3. [~~(c)~~] Meet ventilator dependent patient status requirements established in 907 KAR 1:022.

(b) In addition to the individual meeting the requirements established in paragraph (a) of this subsection:

1. The individual or a representative on behalf of the individual shall:

a. Apply for 1915(c) home and community based waiver services via the MWMA portal;

b. Complete and upload into the MWMA portal a MAP - 115 Application Intake - Participant Authorization; and

c. Complete and upload into the MWMA portal a MAP - 116 Service Plan – Participant Authorization prior to or at the time the person-centered service plan is uploaded into the MWMA portal; and

2. A registered nurse on behalf of the individual applying for services shall:

a. Complete and upload into the MWMA portal:

(i) [;

~~(d) Submit to the department an application packet which shall contain:~~

~~1.~~] A MAP 350, Long Term Care Facilities and Home and Community Based Program Certification Form;

(ii) A person-centered service plan; and

(iii) [~~2.~~] A MAP-351A, Medicaid Waiver Assessment [~~Form~~]; and

b. Upload [~~3.~~] a MAP-10, Waiver Services – Physician's Recommendation [~~MAP109 – MWII, plan of Care/Prior Authorization for Model Waiver II Services,~~] which shall be signed and dated by a physician.

(c) An individual's eligibility for Model Waiver II services shall begin upon receiving [; ~~and~~

~~(e) Receive~~] notification of [~~an admission packet~~] approval from the department.

(2) For an individual to remain eligible for Model Waiver II services:[~~, the requirements established in this subsection shall be met.~~]

(a) The [~~An~~] individual shall:

1. Maintain Medicaid eligibility requirements established in 907 KAR 20:010; and

2. Remain ventilator dependent pursuant to 907 KAR 1:022;[.]

(b) A Model Waiver II level of care determination confirming that the individual qualifies shall be performed and submitted to the department every six (6) months; and [.]

(c) A MAP-10, Waiver Services – Physician's Recommendation [~~109, plan of Care/Prior Authorization for Model Waiver II Services~~] shall be:

1. Signed and dated by a physician every sixty (60) days on behalf of the individual; and

2. Uploaded into the MWMA portal [~~Submitted to the department,~~] after being signed and dated in accordance with subparagraph 1 of this paragraph, every sixty (60) days.

(3) A Model Waiver II service shall not be provided to a recipient who is:

(a) Receiving a service in another 1915(c) home and community based waiver program; or

(b) An inpatient of:

1. A nursing facility;

2. An intermediate care facility for individuals with an intellectual disability; or

3. Another facility.

(4) The department shall not authorize a Model Waiver II service unless it has ensured that:

(a) Ventilator dependent status has been met; and

(b) The service:

1. Is available to the recipient;

2. Will meet the need of the recipient; and

3. Does not exceed the cost of traditional institutional ventilator care.

Section 3. Provider Participation Requirements. To participate in the Model Waiver II program, a:

(1) Home health agency shall:

(a) Be a currently participating Medicaid provider in accordance with 907 KAR 1:671;

(b) Be currently enrolled as a Medicaid provider in accordance with 907 KAR 1:672;

and

(c) Meet the home and community based waiver service provider requirements established in:

1. 907 KAR 1:160; or

2. 907 KAR 7:010; or

(2) Private duty nursing agency shall:

(a) Be a currently participating Medicaid provider in accordance with 907 KAR 1:671;

(b) Be currently enrolled as a Medicaid provider in accordance with 907 KAR 1:672; and

(c) Be a licensed private duty nursing agency in accordance with 902 KAR 20:370.

Section 4. Covered Services. (1) The following shall be covered Model Waiver II services:

(a) Skilled nursing provided by:

1. A registered nurse; or

2. A licensed practical nurse; or

(b) Respiratory therapy.

(2) Model Waiver II services shall be provided by an individual employed by or under contract through a private duty nursing agency or home health agency as a:

(a) Registered nurse;

(b) Licensed practical nurse; or

(c) Registered respiratory therapist.

Section 5. Payment for Services. The department shall reimburse a participating home health agency or private duty nursing agency for the provision of covered Model

Waiver II services as established in this section.

(1) Reimbursement shall be based on a fixed fee for a unit of service provided for each covered service referenced in Section 4 of this administrative regulation with one (1) hour equal to one (1) unit of service.

(2) The fixed fee for skilled nursing services provided by:

(a) A registered nurse shall be thirty-one (31) dollars and ninety-eight (98) cents for each unit of service;

(b) A licensed practical nurse shall be twenty-nine (29) dollars and ten (10) cents for each unit of service; and

(c) A registered respiratory therapist shall be twenty-seven (27) dollars and forty-two (42) cents for each unit of service.

(3) Reimbursement shall not exceed sixteen (16) units of service per day.

(4) Payment shall not be made for a service to an individual for whom it can reasonably be expected that the cost of the 1915(c) home and community based waiver program service furnished under this administrative regulation would exceed the cost of the service if provided in a hospital-based nursing facility.

Section 6. Maintenance of Records. (1) A Model Waiver II service provider shall maintain:

(a) A clinical record for each participant [~~HCB recipient~~] which shall contain [~~the following~~]:

1. Pertinent medical, nursing, and social history;

2. [~~A comprehensive assessment entered on a MAP-351A, Medicaid Waiver Assessment Form, and signed by the:~~

~~a. Assessment team; and~~

~~b. Department;~~

~~3.~~] A person-centered service [~~completed MAP109 MWII,~~] plan [~~of Care/Prior Authorization for Model Waiver II Services~~];

4. A copy of the MAP 350, Long Term Care Facilities and Home and Community Based Program Certification Form signed by the participant [~~recipient~~] or the participant's [~~recipient's~~] legal representative at the time of application or reapplication and each recertification thereafter;

5. Documentation of all level of care determinations;

6. All documentation related to prior authorizations including requests, approvals, and denials;

7. Documentation that the participant [~~recipient~~] or legal representative was informed of the procedure for reporting complaints; and

8. Documentation of each service provided that shall include:

a. The date the service was provided;

b. The duration of the service;

c. The arrival and departure time of the provider, excluding travel time, if the service was provided at the participant's [~~recipient's~~] home;

d. Progress notes which shall include documentation of changes, responses, and treatments utilized to evaluate the participant's [~~recipient's~~] needs; and

e. The signature of the service provider; [~~and~~]

(b) Each MAP-10, Waiver Services – Physician's Recommendation submitted regarding the participant in accordance with Section 2 of this administrative regulation; and

(c) Incident reports as required by Section 7 of this administrative regulation if an incident with the participant [~~recipient~~] occurs.

(2)(a) Except as provided in paragraph (b) of this subsection, a clinical record or incident report shall be retained for at least six (6) years from the date that a covered service is provided.

(b) If the participant [~~recipient~~] is a minor, a clinical record or incident report shall be retained for three (3) years after the participant [~~recipient~~] reaches the age of majority under state law, if that is a longer time period than the time period required by paragraph (a) of this subsection.

(3) Upon request, a provider shall make information regarding service and financial records available to the:

(a) Department;

(b) Cabinet for Health and Family Services, Office of Inspector General or its designee;

(c) United States Department for Health and Human Services or its designee;

(d) General Accounting Office or its designee;

(e) Office of the Auditor of Public Accounts or its designee; or

(f) Office of the Attorney General or its designee.

Section 7. Incident Reporting. (1)(a) There shall be two (2) classes of incidents.

(b) The following shall be the two (2) classes of incidents:

1. An incident; or

2. A critical incident.

(2) An incident shall be any occurrence that impacts the health, safety, welfare, or

lifestyle choice of a participant and includes:

(a) A minor injury;

(b) A medication error without a serious outcome; or

(c) A behavior or situation which is not a critical incident.

(3) A critical incident shall be an alleged, suspected, or actual occurrence of an incident that:

(a) Can reasonably be expected to result in harm to a participant; and

(b) Shall include:

1. Abuse, neglect, or exploitation;

2. A serious medication error;

3. Death;

4. A homicidal or suicidal ideation;

5. A missing person; or

6. Other action or event that the provider determines may result in harm to the participant.

(4)(a) If an incident occurs, the Model Waiver II provider shall:

1. Report the incident by making an entry into the MWMA portal that includes details regarding the incident; and

2. Be immediately assessed for potential abuse, neglect, or exploitation.

(b) If an assessment of an incident indicates that the potential for abuse, neglect, or exploitation exists:

1. The individual who discovered or witnessed the incident shall immediately act to ensure the health, safety, or welfare of the at-risk participant;

2. The incident shall immediately be considered a critical incident;

3. The critical incident procedures established in subsection (5) of this section shall be followed; and

4. The Model Waiver II provider shall report the incident to the participant's registered nurse and participant's guardian, if the participant has a guardian, within twenty-four (24) hours of discovery of the incident.

(5) If a critical incident occurs, the:

(a) Individual who witnessed the critical incident or discovered the critical incident shall immediately:

1. Act to ensure the health, safety, and welfare of the at-risk participant; and

2. Report the critical incident by making an entry in the MWMA portal including details of the incident; and

(b) Model Waiver II provider shall:

1. Conduct an immediate investigation and involve the participant's registered nurse in the investigation; and

2. Prepare a report of the investigation which shall be recorded in the MWMA portal and shall include:

a. Identifying information of the participant involved in the critical incident and the person reporting the critical incident;

b. Details of the critical incident; and

c. Relevant participant information including:

(i) A listing of recent medical concerns;

(ii) An analysis of causal factors; and

(iii) Recommendations for preventing future occurrences.

(6) If a critical incident is not one which requires reporting of abuse, neglect, or exploitation, the critical incident shall be reported via the MWMA portal within eight (8) hours of discovery.

(7) If a death of a participant occurs a Model Waiver II provider shall submit to the MWMA portal mortality data documentation within fourteen (14) days including:

(a) The participant's person-centered service plan at the time of death;

(b) Any current assessment forms regarding the participant;

(c) The participant's medication administration records from all service sites for the past three (3) months along with a copy of each prescription;

(d) Progress notes regarding the participant from all service elements for the past thirty (30) days;

(e) The results of the participant's most recent physical exam;

(f) All incident reports, if any exist, regarding the participant for the past six (6) months;

(g) Any medication error report, if any exists, related to the participant for the past six (6) months;

(h) A full life history of the participant including any update from the last version of the life history;

(i) Names and contact information for all staff members who provided direct care to the participant during the last thirty (30) days of the participant's life;

(j) Emergency medical services notes regarding the participant if available;

(k) The police report if available;

(l) A copy of:

1. The participant's advance directive, medical order for scope of treatment, living will, or health care directive if applicable; and

2. The cardiopulmonary resuscitation and first aid card for any provider's staff member who was present at the time of the incident which resulted in the participant's death;

(n) A record of all medical appointments or emergency room visits by the participant within the past twelve (12) months; and

(o) A record of any crisis training for any staff member present at the time of the incident which resulted in the participant's death.

(8) A Model Waiver II provider shall report a medication error by making an entry into the MWMA portal [~~A Model Waiver II service provider shall:~~

~~(1) Implement a procedure or procedures to ensure that the following is reported:~~

~~(a) Abuse, neglect, or exploitation of a Model Waiver II recipient in accordance with KRS Chapters 209 or 620;~~

~~(b) A slip or fall;~~

~~(c) A transportation incident;~~

~~(d) Improper administration of medication;~~

~~(e) A medical complication; or~~

~~(f) An incident caused by the recipient, including:~~

~~1. Verbal or physical abuse of staff or other recipients;~~

~~2. Destruction or damage of property; or~~

~~3. Recipient self-abuse;~~

~~(2) Ensure that a copy of each incident reported in this subsection is maintained in a~~

~~central file subject to review by the department; and~~

~~(3) Implement a process for communicating the incident, the outcome, and the prevention plan to:~~

~~(a) The Model Waiver II service recipient involved, his or her family member, or his or her responsible party; and~~

~~(b) The attending physician, physician assistant, or advanced practice registered nurse~~].

Section 8. Use of Electronic Signatures. [~~(1)~~] The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

[~~(2) A Model Waiver II service provider that chooses to use electronic signatures shall:~~

~~(a) Develop and implement a written security policy that shall:~~

~~1. Be adhered to by each of the provider's employees, officers, agents, and contractors;~~

~~2. Identify each electronic signature for which an individual has access; and~~

~~3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;~~

~~(b) Develop a consent form that shall:~~

~~1. Be completed and executed by each individual using an electronic signature;~~

~~2. Attest to the signature's authenticity; and~~

~~3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and~~

~~(c) Provide the department with:~~

~~1. A copy of the provider's electronic signature policy;~~

~~2. The signed consent form; and~~

~~3. The original filed signature immediately upon request.~~]

Section 9. Federal Financial Participation. The department's coverage of and reimbursement for Model Waiver II services pursuant to [~~A policy established in~~] this administrative regulation shall be contingent upon [~~null and void if the Centers for Medicare and Medicaid Services~~]:

(1) [~~Denies~~] Federal financial participation for the coverage and reimbursement [~~policy~~]; and [~~or~~]

(2) Centers for Medicare and Medicaid Services' approval for the coverage and reimbursement [~~Disapproves the policy~~].

Section 10. Appeal Rights. (1) An appeal of a negative action regarding a Medicaid recipient shall be appealed in accordance with 907 KAR 1:563.

(2) An appeal of a negative action regarding a Medicaid beneficiary's eligibility shall be appealed in accordance with 907 KAR 1:560.

(3) An appeal of a negative action regarding a Medicaid provider shall be appealed in accordance with 907 KAR 1:671.

Section 11. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "MAP - 115 Application Intake - Participant Authorization", June 2015 [~~109 - MWII, Plan of Care/Prior Authorization for Model Waiver II Services", April 2004 edition~~];

(b) "MAP 350, Long Term Care Facilities and Home and Community Based Program

Certification Form", June 2015 [~~January 2000 edition; and~~]

(c) "MAP-10 Waiver Services – Physician's Recommendation", June 2015;

(d) "MAP - 116 Service Plan – Participant Authorization", June 2015; and

(e) 351A, Medicaid Waiver Assessment [~~Form~~]", July 2015 [~~June 15, 2002 edition~~].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law:

(a)[,] At the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.; or

(b) Online at the department's Web site at http://www.chfs.ky.gov/dms/incorporated.htm.

907 KAR 1:595

REVIEWED:

7-7-15
Date

Lisa Lee, Commissioner
Department for Medicaid Services

APPROVED:

8/13/15
Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

907 KAR 1:595

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on September 21, 2015 at 9:00 a.m. in Suite B of the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing September 14, 2015, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until September 30, 2015. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:595
Contact: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the service coverage and reimbursement policies for the Medicaid Model Waiver II services. This program enables individuals who have nursing facility level of care needs primarily due to needing to be on a ventilator for at least twelve (12) hours per day to be able to receive services in the home rather than being admitted to a nursing facility.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the service coverage and reimbursement policies for the Medicaid Model Waiver II services.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the service coverage and reimbursement policies for the Medicaid Model Waiver II services.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing the service coverage and reimbursement policies for the Medicaid Model Waiver II services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendment requires individuals to apply for services via an online portal – Medicaid Waiver Management Application (MWMA) – mandated by the Centers for Medicare and Medicaid Services (CMS) and revises incident reporting provisions including the requirement that incidents be recorded in the MWMA portal.
(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to comply with a federal mandate.
(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with a federal mandate.
(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by complying with a federal mandate.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Individuals receiving Model Waiver II services, home health agencies, and private duty nursing agencies will be affected by the amendment. There are currently forty-three (43) individuals

receiving services via the program and a total of nineteen (19) providers – home health agencies and private duty nursing agencies combined – enrolled as Model Waiver II service providers.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Individuals will have to apply for services via an online portal.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Applicants should benefit from a streamlined application process.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: DMS anticipates that the amendment to this administrative regulation will be budget neutral initially.
(b) On a continuing basis: DMS anticipates that the amendment to this administrative regulation will be budget neutral on a continuing basis.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding is necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is not applied as the requirements apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:595
Agency Contact Person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 C.F.R. 441.305(b).

2. State compliance standards. KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. No more than 200 individuals may receive services at any one time via a Model Waiver.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 1:595
Contact: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendment is not expected to generate revenue for state or local government.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The amendment is not expected to generate revenue for state or local government.
   (c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) anticipates that the amendment to this administrative regulation will be budget neutral in the first year.
   (d) How much will it cost to administer this program for subsequent years? DMS anticipates that the amendment to this administrative regulation will be budget neutral in subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Revenues (+/-):
Expenditures (+/-):
Other Explanation:

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:595

Summary of Material Incorporated by Reference

(1) The Department for Medicaid Services (DMS) is adding the following to the material incorporated by reference:

(a) "MAP – 115 Application Intake – Participant Authorization", May 2015 which is a one (1) page form used to individuals to designate someone to represent them in applying for services and doing so online via the new Medicaid Waiver Application Management (MWMA) portal;
(b) "MAP – 116 Service Plan – Participant Authorization", May 2015 which is a one (1) page form used to individuals to designate someone to represent them in developing a person-centered service plan;
(c) "MAP - 10 Waiver Services – Physician's Recommendation", June 2015 which is a one (1) page form used to document an individual's need for waiver services.

(2) The following incorporated material is being revised:
(a) "MAP 350, Long Term Care Facilities and Home and Community Based Program Certification Form", June 2015 - which is a two (2) page form used to document individual's understanding of the option to receive waiver services and related provisions – replaces the July 2000 version and is revised to replace the term "mental retardation" with "intellectual disability" and "ICF/MR/DD" with "ICF IID";
(b) "MAP 351, Medicaid Waiver Assessment", July 2015 – which is a fifteen (15) page document used to assess the needs of an individual applying for waiver services to help determine if they qualify for services. The June 2015 version replaces the July 2008 version. Revisions include changing the term "mental retardation" to "intellectual disability", "consumer" to "participant", "consumer directed option" or "CDO" to "participant directed services" or "PDS", and removing references to the Supports for Community Living (SCL) waiver as the form is no longer used for that waiver.

A total of twenty (20) pages is incorporated by reference.